STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155666	A. BUILDING 00 B. WING	04/08/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESLEY HEALTHCARE	1751 WESLEY ROAD AUBURN, IN46706

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F0000	This visit was for a Recertification and Licensure Survey. This visit included the Investigation of Complaint number IN00088668. Complaint number IN00088668 Substantiated. Federal/state deficiencies related to the allegations are cited at F241, F272 and F441. Survey dates: April 4, 5, 6, 7, and 8, 2011 Facility number: 000307 Provider number: 155666 AIM number: 100285660 Survey team: Christine Fodrea, RN, TC Sheryl Roth, RN Rick Blain, RN Sue Brooker, RD Census bed type: SNF/NF: 43 Total: 43 Census payor type: Medicare: 4 Medicaid: 30 Other: 9 Total: 43	F0000	This plan of correction is prepared and executed because the provisions of the state and federal law require it. This plan of correction shall not be deemed an admission to or agreement with the survey allegations. Wesley Healthcare Center maintains that the alleged deficiencies do not individually or collectively jeopardize the health and safety of our residents, nor are they of such character so as to limit our capability to render adequate care. Wesley Healthcare Center further maintains that the allegations set forth herin do not substantiate or constitute sub standard quality of care. Please accept the last date noted on the plan of correction as the facilities credible allegation of compliance.Wesley Healthcare requests paper compliance as these deficiencies were not severe and posed no actual harm to residents.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Sample: 13 These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2. Quality review completed 4-13-11 Cathy Emswiller RN			
F0166 SS=E	A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. Based on record review and interview, the facility failed to ensure resident grievances regarding call lights for 8 of 8 residents in group meeting were promptly addressed/thoroughly investigated on 3 of 3 monthly resident council minutes reviewed. (Residents' #B, C, D, E, F, G, H, AND I) Findings include: During the group meeting held on 4/5/11 at 2:00 p.m. with 8 residents identified during interview with the Activity Director on 4/5/11 at 2:00 p.m. as alert and oriented, 8 of 8 residents present [residents' B, C, D, E, F, G, H, & I] indicated continued concerns with call lights being answered by staff, turned off,	F0166	1. In-service as per attached completed with all staff on 4/18/112. Speak to 10 residents 1x per week x 2 months, 2x per month x 2 months, 1x per month x 2 months on a ramdom basis and document on log attached. This will ensure that if that resident has had an issue with a call light being answered but the need not addressed, the resident will more likely be able to identify the responsible staff member/shift. 3. DON or designee to work 2nd/3rd shift at minimum 1x per week x 2 months. 2x per month x 2 months, 1x per month x 2 months to monitor care for all residents including non-alert/orientated residents to ensure that good care is being provided.4. DON or ADON will continue to go to resident council to answer any	04/25/2011

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	and then telling the resident they would be back to help them. The residents further indicated they had complained about the call lights in past resident council meetings. During the group meeting on 4/5/11 at 2:00 p.m., Resident #B indicated having an incontinent accident while waiting on the call light to be answered. The resident further indicated there just isn't enough staff to take care of everybody's needs. At night, one girl may work 2 floors at times. A review of "Resident Council Minutes," indicated the following concerns with call lights: - 1/4/11: Second shift nurses are turning off the call lights and not doing what was needed. They were told the facility was aware of the issue and was already addressing it. A typed follow-up indicated a letter was posted to nursing which indicated when they answer a call light and are unable to perform the task, they are to leave the call light on until the resident's needs are met. "...Do not shut off call lights you need to do what is needed when it is needed otherwise you will get busy and forget to go back!!!!...." - 2/1/11: Call lights continue to get turned off without the nurses doing what needs done. The written follow up indicated concerns with call lights on west hall were		concerns with residents5. QA to follow X 6 months	

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	received from resident council but when speaking with the nurse, the nurse indicated she did not believe this was true. The response further indicated the nurse was instructed to pass on the information in report that nurses are responsible for lights and must ensure the resident's needs are met prior to leaving the residents rooms. The note indicated the call light logs were reviewed and did not show call lights on for long periods of time but did not address whether staff were monitored or what was being done to ensure residents were receiving the required care other than the posting of a note to the nurses and that two residents would periodically be asked regarding follow-up to call light concerns. - 3/1/11: Call lights continue to be turned off without request being completed. No written follow-up provided to resolution of resident council complaint. The Director of Nursing was interviewed on 4/8/11 at 9:30 a.m. She indicated the Assistant Director of Nursing (DON) comes in at all hours to monitor CNAs while she's doing wound care, etc. The DON indicated she reviewed the call light log to check length call lights were on and whether the lights get turned back on repeatedly. A request was made to the DON on 4/8/11			

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	at 9:40 a.m. for the call light logs. No logs were provided as of exit on 4/8/11 at 11:07 a.m. nor was any further follow-up or monitoring of the call lights or responses to resident council. 3.1-7(a)(2)			
F0241 SS=D	The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. Based on observation, interview, and record review, the facility failed to ensure privacy during respiratory treatments for 2 of 4 residents reviewed for privacy during respiratory treatments in a sample of 13. (Resident #D and Resident #E) Findings include: 1. Resident #D's record was reviewed on 4/4/2011 at 11:30 a.m. Resident #D's diagnoses included, but were not limited to, Guillian-Barre' syndrome (paralysis advancing from foot to head), respiratory failure, and chronic pain. During an observation of tracheostomy care on Resident #D given by Respiratory Therapist (RT) #8 on 4/5/11 at 11:10 a.m., RT #8 performed suctioning and	F0241	1. In-service as per attached completed on 4/18/112. Policy for Privacy/Dignity revised-staff in-serviced at above mentioned in-service3. DON or designee to monitor for privacy/dignity issues by direct observation 1x per week x 2 months, 2x per month x 2 months, 1x per month x 1 month. Document on attached log.4.QA to follow x 6 months	04/25/2011

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	tracheostomy care while the window blinds, room curtains, and the room door were open. Certified Occupational Therapy Aide (COTA) #9 was performing range of motion with Resident #D's roommate. The husband of Resident #D's roommate entered the room during the procedures and standing by Resident #D's chest of drawers proceeded to watch the procedure. RT #8 did not asked the roommate's husband to leave. Resident #D had not given permission for any observation of the procedure. Six unidentified persons walked past the room able to fully visualize Resident #D during the procedure. Two unidentified individuals walked past the room window during the procedure. Resident #D indicated an interview on 4/5/11 at 2 p.m. she would have liked the room curtain closed. 2. Resident #E's record was reviewed on 4/5/2011 at 2:25 p.m. Resident #E's diagnoses included, but were not limited to, spinal cord infarction (death of part of the spinal cord), respiratory failure, and anemia. During an observation of tracheostomy care on Resident #E given by RT #8 on 4/6/11 at 11:00 a.m., RT #8 performed suctioning and tracheostomy care while			

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	the window blinds, and the room door was open. Resident #E had not given permission for any observation of the procedure. Three unidentified persons walked past the room able to partially visualize Resident #E during the procedure. One unidentified individual walked past the room window during the procedure. Resident #E indicated during an interview on 4/7/11 at 11:00 a.m. he would have liked to have had the room door closed. In an interview on 4/6/11 at 9:00 a.m. the Director of Nursing indicated the resident should have been able to have privacy during care. A current undated policy provided by the Director of Nursing on 4/7/11 at 8:30 a.m. titled Visits-Privacy-Confidentiality You have the right to: indicated the resident had the right to privacy in their room and during medical treatment and personal care. This Federal tag relates to complaint number IN00088668. 3.1-3(t)			

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F0246 SS=D	A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. Based on observation, record review and interview, the facility failed to ensure the call light was accessible for 1 of 13 residents reviewed with call lights in a sample of 13 residents (Resident #10). Findings include: Resident #10's record was reviewed on 4/5/11 at 10:45 a.m. The record indicated Resident #10's diagnoses included, but were not limited to, lung cancer and right nephrectomy (kidney removal). On 4/5/11 at 9:30 a.m. and 10:38 a.m., Resident #10 was observed sitting up in a wheelchair, in her room, with no call light within reach. The current policy and procedure "Call Lights," dated 10/5/09, was provided by the Director of Nursing (DON) on 4/7/11 at 8:30 a.m. The policy indicated to "...Place the call light in reach prior to leaving the residents room...."	F0246	1. In-service as per attached completed 4/18/112. DON or designee to monitor via direct observation of all rooms 1x per week x 2 months, 2x per month x 2 months, 1x per month x 2 months. Documented on attached log.3. QA to follow x 6 months	04/25/2011

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	The "Plan of Treatment" dated 3/11/11, for Resident #10, indicated the resident was able to feed herself independently without impairment. During an interview on 4/6/11 at 3:15 p.m., LPN #13 indicated call lights should be within reach of the resident. 3.1-3(v)(1)			
F0248 SS=E	The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. Based on record review and interview, the facility failed to offer activities into the community for 4 of 8 residents interviewed for activities in a sample of 13 residents. (Resident #60, #61, #62, #63) Findings include: During the group meeting with alert and oriented residents as noted by the Activities Director on 4/5/11 at 2:00 p.m.,	F0248	1. Wal-mart shopping removed from activities calendars2. Request sheet initiated by Activities Director to be distributed to residents to fill out if they wish to go to an outside activity. All reasonable requests (within a 10 mile radius of the facility) will be granted but will have to be scheduled around physician appointments and other times such as service that the van may not be available. Activities farther than 10 miles, or those that require	04/25/2011

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	4 of 8 (Resident #60, #61, #62, #63) residents in attendance indicated they would like to attend activities outside of the facility but haven't been out of the building in over a year, unless it was for a medical appointment. They indicated some of their interests included van rides, looking at Christmas lights and shopping. The current policy "Activities," dated 1/13/11, was provided by the Director of Nursing on 4/8/11 at 8:45 a.m. The policy indicated "...all residents are encouraged to attend the daily activities...on the activity census sheet, mark who was in attendance for the activity...mark each residents calendar with what activity they did for the day...." Activity attendance records for all residents in the facility were provided by the Activities Director on 4/8/11 at 8:30 a.m. Of the 42 calendars for the month of March, 12 residents were marked as having attended the outside activity of Walmart on 3/911 including Resident #61 and #62) and 14 as having attended on 3/23/11 including Resident #60 and #61. Of the 43 calendars for the month of April, 12 residents were marked as having attended the outside activity of Walmart on 4/6/11 including Residents' #60, #61, and #62.		additional staff besides the Activities Director or Van Driver will need approval of the Administrator or Executive Director.3. Activities Director to keep log of all outside events and who attended x 6 months4. Activities Director will be present at resident council to address any concerns about activities4. QA to follow x 6 months	

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	During interview on 4/7/11 at 2:33 p.m., the Activity Director indicated she provides monthly calendars to the residents and that the activities are also listed on the bulletin board. She indicated she sits down with the residents and interviews them upon admission regarding their interests. She indicated none of the residents have been outside the facility on an activity in the last year and that they can go out with their families if they wish. She indicated she had several residents throughout the year wanting to go outside the facility but she told them she would have to set it up with a local transportation company which would require a fee. When asked about the Walmart outing on the calendar, she indicated no one goes to Walmart, the resident's just have her purchase items for them from Walmart. 3.1-33(a) 3.1-33(b)(3)			

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F0272 SS=D	The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed through the resident assessment protocols; and Documentation of participation in assessment. Based on record review and interview, the facility failed to ensure 3 of 6 residents reviewed for infections and the use of antibiotic medication were assessed while being treated for an infection in a sample of 13 residents [Resident #20, Resident #30, and Resident #E]. Findings include:	F0272	1. In-service as per attached completed on 4/18/112. Policy updated to include that all patients receiving antibiotic therapy are to be assessed for adverse reactions to the antibiotic, how they are responding to the antiobiotic therapy, and documentation specific to that infection to indicate if the patient is responding appropriately to the	04/25/2011

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	The record for Resident #20 was reviewed on 4/5/11 at 5:15 P.M. Diagnoses included, but were not limited to, recurrent urinary tract infections [UTI] and urinary retention. The record also indicated the resident had a Foley catheter [an indwelling urinary catheter]. A nursing note, dated 2/27/11 at 10:00 A.M., indicated Resident #20 was noted to have blood around his penis and the Foley catheter was draining dark yellow urine with clots of blood. A nursing note, dated 2/27/11 at 1:00 P.M., indicated Resident #20 continued to have bleeding noted on his penis. The physician was notified and orders were received to send the resident to the emergency room. An emergency room report, dated 2/27/11, indicated a urinalysis obtained at the emergency room indicated bacteria and blood cells in the urine. The note indicated the resident was administered Rocephin [antibiotic medication] intravenously while at the hospital and Cipro [antibiotic medication] 500 mg [milligrams] twice daily for ten days was prescribed. The note indicated the resident was diagnosed with a urinary tract infection. The note indicated the		antiobiotic therapy at a minimun of 1x per 24hrs until the antiobiotic is completed.3. DON or designee to monitor charting of all patients on antibiotics 1x per week x 2 months, 2x per month x 2 months, 1x per month x 2 months. Documentation on attached log.4. QA to follow x 6 months	

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	resident was discharged back to the nursing facility. A nursing note, dated 2/27/11 at 6:45 P.M., indicated Resident #20 had returned from the emergency room with a prescription for Cipro and that results for a urine culture test were pending. A physician's order, dated 3/1/11, indicated the Cipro was discontinued secondary to the organism in the urine not being susceptible to Cipro. The order indicated Macrobid [antibiotic medication] 100 mg twice daily for seven days was to be administered. A physician's order, dated 3/2/11, indicated the Macrobid was to be discontinued and Bactrim DS [antibiotic medication] twice daily for ten days was started. A nursing note, dated 3/3/11 with no time documented, indicated "Res [resident] continues ATB [antibiotic] for UTI. [No] adverse reaction noted. T-97.5 [temperature]. There was no assessment of the urine color or clarity, patency of the Foley catheter, or pain. A nursing note, dated 3/7/11 at 8:00 A.M., indicated "Res continues ATB for UTI. [No] adverse reactions noted. T-98".			

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	There was no assessment of the urine color or clarity, patency of the Foley catheter, or pain. There were no other entries in Resident #20's record regarding his temperature or assessments regarding the antibiotic medications or UTI while being treated for the UTI. LPN #5 was interviewed on 4/7/11 at 2:40 P.M. During the interview, LPN #5 indicated any residents being treated with antibiotics for infections were to be assessed at least once each shift. LPN #5 indicated the assessment was to include the resident's temperature and observations for adverse reactions to the antibiotic medication. LPN #5 indicated the assessments were to continue until the resident was no longer taking the antibiotic and the infection had resolved and the assessments were to be documented in the nursing notes. The Director of Nursing [DON] was interviewed on 4/7/11 at 2:45 P.M. During the interview, the DON indicated nurses were to assess any residents being treated for infections with antibiotic medications at least once per shift. The assessments were to include the resident's temperature and observations for adverse reactions to the antibiotics. The			

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESLEY HEALTHCARE	1751 WESLEY ROAD AUBURN, IN46706

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	assessments were to be documented in the nursing notes. The DON indicated the assessments were to continue until the resident was no longer taking the antibiotic medication. The DON indicated the facility did not have a policy regarding assessment of residents with infections. 2. Resident #30's record was reviewed 4/6/11 at 1:15 p.m. Resident #30's diagnoses included, but were not limited to, congestive heart failure, respiratory failure, and high blood pressure. A physician's order for chest x-ray dated 3/31/11 indicated the test was ordered for increased shortness of breath and an increase in need for suctioning. A review of nurse's notes dated 3/29, 3/30 and 3/31/11 did not indicate an increased need for suctioning or an increase in shortness of breath. The notes did not indicate the rate and quality of breath sounds, whether there was a cough and whether the cough was productive, the type of sputum. The chest x-ray result dated 3/31/11 indicated Resident #30 had a right lower lobe infiltrate. On 4/1/11 at 6:30 p.m., a nurses note indicated Levaquin (an antibiotic), and a sputum culture had been ordered for the			

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	right lower lobe infiltrate. A review of the nurse's notes for 4/1, 4/2, 4/3, 4/4, 4/5, and 4/6/11 did not include any assessment of the rate and quality of breath sounds, if there was a cough and if the cough was productive, the type of sputum. 3. Resident #E's record was reviewed 4/5/11 at 2:25 p.m. Resident #E's diagnoses included but were not limited to, spinal cord infarction (death if part of the spinal cord), kidney failure, and anemia. A physician's order dated 3/23/11 indicated to give Ciloxin (an antibiotic) eye drops and to obtain an eye culture of eye drainage. A review of nurse's notes dated 3/22, 3/23, 3/24, 3/25, 3/26, 3/27, 3/28 and 3/29/11 did not indicate any eye drainage was present. Additionally, there was no description of the eye or surrounding area to indicate an infection existed. This Federal tag relates to complaint number IN00088668. 3.1-31(a)			

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F0278 SS=D	The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement.			

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	Based on observation, record review and interview, the facility failed to ensure an accurate Minimum Data Set (MDS) Assessment for 1 of 13 residents reviewed for MDS accuracy in a sample of 13 residents. (Resident #1) Findings include: Resident #1's record was reviewed on 4/4/11 at 11:25 a.m. The record indicated Resident #1's diagnoses included, but were not limited to, respiratory failure (ventilator dependant) and complete vegetative state. The quarterly minimum data set (MDS) assessment, dated 2/13/11, indicated Resident #1 required extensive assistance with eating. The supporting documenting for eating, completed by CNA staff for the time frame, listed the resident as either totally dependant (full staff performance) or activity did not occur, or limited or limited assistance (resident highly involved). A physician progress note, dated 2/24/11, indicated Resident #1 was almost totally comatose (coma state) and that she will occasionally flutter her eyes a little bit but no other real response for a number of months. The progress note, dated 2/9/11, indicated the resident was ventilator	F0278	1. In-service as per attached for all staff completed on 4/18/112. DON or designee to monitor ADL grid charting for accuracy and completeness 1x per week x 2 months, 2x per month x 2 months, 1x per month x 2 months. Documentation per attached log.3. MDS will code dependent patients as dependent for eating per state request even if hole is present in ADL grid4. QA to follow x 6 months5.5. Will review all residents and identify those dependent for adl's and correct the MDS as affected. This will be done and corrected on 5/2/11.	04/25/2011

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	dependant, nonresponsive to her environment and in a complete vegetative state. The "Nutritional Progress Notes," dated 2/11/11, indicated Resident #1 was NPO (nothing by mouth) and received tube feed nutrition thru a feeding tube. During interview on 4/7/11 at 10:00 a.m., the MDS nurse indicated she's goes by the CNA documentation for coding the MDS. She indicated if someone was receiving nutrition solely by tube feeding, that person would be coded as dependant for eating but she would have to code it less than dependant if the charting had a whole in the documentation or if the CNA coded it wrong. 3.1-31(d)			

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F0279 SS=D	A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). Based on record review and interview, the facility failed to ensure care plans were completed with goals, time frames, disciplines involved, etc. for 1 of 13 residents reviewed for care plans (Resident #10). The facility further failed to ensure behavior recommendations from the Psychologist were incorporated into the care plan for 1 of 5 residents reviewed with behaviors (Resident #5) and failed to develop a care plan to address delusional behavior for 1 of 9 residents reviewed for psychotropic medications and behaviors in a sample of 13 residents (Resident #20). Findings include:	F0279	1. Policy revised to include how a care plan is to be written as per attached policy.2. All Social Service care plans reviewed/updated by SSD to ensure that all care plans are complete with goals, measurable time frame, and disiplines involved.3. All Psychologist notes to be reviewed by SSD, and will be incorporated into the care plan where applicable. 4. Initial care-plan updated with a measurable time frame. 5. SSD to review all current care plans to ensure that all patients with psych meds and/or psych dx have an applicable care plan.6. All Nursing care plans and SS care plans re-done per new policy to include goals, time frames, and disiplines.7. Nursing and SS Care	04/25/2011

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	1. Resident #10's record was reviewed on 4/5/11 at 10:45 a.m. The record indicated Resident #10's diagnoses included, but were not limited to, lung cancer and right nephrectomy (kidney removal). The following "Social Service Care Plans," all dated 3/15/11, did not include time frames for resolution or re-evaluation of goals nor did it include the disciplines involved in the interventions: impaired cognition/communication/decision making skills/impaired memory, code status, spouse in the community, discharge home, risk for altered communication. The "Initial Care Plan" for Resident #10 for lung cancer, allergies, activities of daily living and risk for falls did not contain time frames for the resolution or re-evaluation of the goals listed. The current policy and procedure "Nursing Care Plans," dated 10/01/10, was provided by the Minimum Data Set Assessment (MDS) Nurse on 4/5/11 at 5:20 p.m. The policy indicated all residents will have an initial nursing care plan completed by the admitting nurse at the time of admission and that other care plans, i.e. diagnosis related, will be completed by the MDS nurse or designee. There was no indicated in the policy on		plans to be audited for accuracy q month x 6 months8. QA to follow x 6 months	

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	how the care plan should be written, i.e. goal timeframe's or the listing of disciplines involved (RN, LPN, CNA, etc.). During interview on 4/5/11 at 5:20 p.m., the MDS Nurse indicated care plans should list a problems area along with a goal and interventions just like typical nursing care plans. 2. Resident #5's record was reviewed on 4/5/11 at 5:00 p.m. The record indicated Resident #5's diagnoses included, but were not limited to, schizophrenia and developmental disability. A progress note from the psychologist, dated 1/18/11, indicated the reason Resident #5 was being seen was for verbal and physical abuse, agitation/distress, anxiety, confusion, fearfulness, hallucinations and delusions. Numerous recommendations were noted on the evaluation regarding behavior management but none were noted to have been included in the residents care plans after 1/18/11. During interview on 4/6/11 at 3:15 p.m., the Director of Nursing indicated when contracted service come in for services, they usually file their own report and flag			

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	them if there are any new orders. 3. The record for Resident #20 was reviewed on 4/5/11 at 5:15 P.M. Diagnoses included, but were not limited to, delusional disorder. A physician order monthly recap for March 2011 indicated Resident #20 was prescribed Risperdal [antipsychotic medication] 1 mg [milligram] daily at bedtime. A "Note to the Attending Physician/Prescriber" form from the consultant pharmacist, dated 12/15/10, indicated the physician was prescribing Risperdal to treat Resident #20's delusional disorder. A review of the current care plans, dated 3/14/11, indicated there was no care plan in Resident #20's record to address delusions or delusional behavior. The facility DON [Director of Nursing] and SSD [Social Services Director] were both interviewed on 4/7/11 at 11:45 A.M. During the interview, the DON indicated Resident #20 exhibited delusional thinking by making inappropriate statements and also exhibited other behaviors that may be related to delusional thinking. The DON indicated the physician had interviewed Resident			

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	#20 and had arrived at the diagnosis of Delusional Disorder during the interview with the resident. Both the DON and SSD indicated the facility had not developed a care plan to address the resident's delusional behavior. They both indicated that a care plan would be of value to staff caring for Resident #20. 3.1-35(a) 3.1-35(b)(1) 3.1-35(b)(2)			
F0280 SS=D	The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. Based on observation, interview, and	F0280	1. Speech Therapy to review all	04/25/2011

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	record review, the facility failed to ensure care plans were updated for 1 of 3 residents reviewed for accurate diet care plans in a sample of 13. (Resident #E) Findings include: Resident #E's record was reviewed on 4/5/11 at 2:25 p.m. Resident #E's diagnoses included but were not limited to, high blood pressure, kidney failure, and spinal cord infarction (part of the spinal cord dies). A physician's order for full liquid diet to supplement tube feeding was written on 3/24/11. On 4/5/11 at 6 p.m., Resident #E was observed eating pudding and applesauce during supper service. In an interview on 4/6/11 at 11:43 a.m. Speech Language Pathologist (SLP) #10 indicated the diet upgrade was a trial to progress Resident #41's intake as he would tolerate it. A review of Resident #E's care plans on 4/5/2011 indicated Resident #E was still NPO (nothing by mouth). In an interview on 4/8/11 at 10 a.m., the Minimum Data Set coordinator indicated		current care plans for accuracy2. Speech Therapist to meet with Dietician weekly (when both are available) to coordinate care on patients being followed by the Speech Therapist to ensure good communication and continuity of care. This is scheduled to begin 4/22/11. This occured due to this patient was being seen by speech but it was the physician and the dietician upgrading his diet not the speech therapist, the ST had him as NPO on his care plan. We initiated the above meeting for the dietician and the speech therapist to avoid this error in the future.3. Dietary Manager to compare his orders to the dietician orders to ensure that all current residents diet orders/diet recomendations are correct. Scheduled to be completed 4/22/11.4. QA to follow x 6 months	

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	care plans were to be updated. 3.1-35(d)(2)(B)			
F0281 SS=D	The services provided or arranged by the facility must meet professional standards of quality. Based on observation, record review and interview, the facility failed to ensure an accurate Minimum Data Set (MDS) Assessment and information used to determine the assessments was not obtained from stafff not qualified to assess, for 1 of 13 residents reviewed for MDS accuracy in a sample of 13 residents. (Resident #1) Findings include: Resident #1's record was reviewed on 4/4/11 at 11:25 a.m. The record indicated Resident #1's diagnoses included, but were not limited to, respiratory failure (ventilator dependant) and complete vegetative state. The quarterly minimum data set (MDS) assessment, dated 2/13/11, indicated Resident #1 required extensive assistance	F0281	1. In-service completed as per attached 4/18/112. DON or designee to monitor ADL grid charting for accuracy and completeness 1x per week x 2 months, 2x per month x 2 months, 1x per month x 2 months 3. MDS will code dependent patients as dependent for eating per state request even if hole is present in ADL grid4. QA to follow x 6 months5. Will review all residents and identify those dependent for adl's and correct the MDS as affected. This will be done and corrected on 5/2/11.	04/25/2011

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	with eating. The supporting documenting for eating, completed by CNA staff for the time frame, listed the resident as either totally dependant (full staff performance) or activity did not occur, or limited or limited assistance (resident highly involved). A physician progress note, dated 2/24/11, indicated Resident #1 was almost totally comatose (coma state) and that she will occasionally flutter her eyes a little bit but no other real response for a number of months. The progress note, dated 2/9/11, indicated the resident was ventilator dependant, nonresponsive to her environment and in a complete vegetative state. The "Nutritional Progress Notes," dated 2/11/11, indicated Resident #1 is NPO (nothing by mouth) and received tube feed nutrition thru a feeding tube. On 4/7/11 at 10:00 a.m., the MDS nurse indicated she's goes by the CNA documentation for coding the MDS. She indicated if someone is receiving nutrition solely by tube feeding, that person would be coded as dependant for eating but she would have to code it less than dependant if the charting had a whole in the documentation or if the CNA coded it wrong.			

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	3.1-35(g)(1)			
F0282 SS=D	The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on observation, record review, and interview, the facility failed to ensure 1 of 1 residents reviewed for the use of adaptive eating equipment was furnished the adaptive equipment as care planned and as ordered by the physician in a sample of 13 residents [Resident #6]. The facility further failed to upgrade a diet from Mechanical Soft to Regular consistency as ordered for 1 resident (Resident #3) and also failed to apply TED hose as ordered for 2 of 2 residents reviewed with orders for Ted hose (Resident #3 and Resident #29) in a sample of 13. Findings include: 1. The record for Resident #6 was reviewed on 4/5/11 at 11:00 A.M. Diagnoses included, but were not limited to, dementia. An Occupational Therapy Progress Report, dated 11/18/10 through 11/24/10, indicated "worked with pt [patient] on weighted silverware for meal times and also a divided plate."	F0282	1. In-service completed as per attached on 4/18/112. Physician telephone orders to be read daily M-F at clinical am meeting where all department heads including Dietary are present. 3. DON or designee to check telephone orders against the TAR/MAR to ensure that the order was transcribed and is transcribed accurately 1x per week x 2 months, 2x per month x 2 months, 1x per month x 2 months. Documented per attached log.4. DON or designee to audit C.N.A sheet against patients (direct observation of residents as compared to C.N.A sheet) to ensure all interventions such as ted hose are present on the patient. 1x per week x 2 months, 2x per month x 2 months, 1x per month x 2 months. Documented per attached.5. Diet was upgraded as per physicians order, Weighted silverware was d/c'd as this patient is assisted at meals, Ted hose were placed on the patients that did not have them on.6. All	04/25/2011

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	A physician's order, dated 11/24/10, indicated Resident #6 was to utilize weighted silverware for all meals. A Nutritional Progress Note, dated 11/26/10, indicated Resident #6 was to use weighted silverware at meals to assist her with self feeding. A Dietary Health Care Plan, dated 11/26/10, indicated Resident #6 was to use self help feeding devices for self feeding. On 4/5/11 at 6:00 P.M., Resident #6 was observed to be in the main dining room eating supper. She was seated at a table with three other residents. She was observed to be attempting to eat with regular non-weighted silverware. Resident #6's hand was observed to be shaking as she attempted to eat rice with the non-weighted spoon. She was observed to have difficulty keeping the rice from spilling from the spoon as she attempted to eat. She was observed to lay the spoon down. Staff was observed to then begin feeding her at that time and fed her the remainder of the meal. On 4/6/11 at 12:15 P.M., Resident #6 was observed to be in the main dining room eating lunch. She was seated at a table with three other residents. She was observed to be attempting to use regular non-weighted silverware. She was observed to attempt to eat cooked carrots with a regular spoon. Her hand was observed to be shaking and she kept spilling the carrots off of the spoon. She was observed to lay the spoon down and she stopped attempting to feed herself. Staff were then observed to begin feeding her for the remainder of the meal.		diet orders including orders for special eating equipment were audited for accuracy, aid sheet was audited against all residents to ensure that all patients has present the intervention listed on the sheet. DON reviews all orders written and updates the C.N.A sheets as appropriate.5. QA to follow x 6 months	

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	On 4/7/11 at 12:10 P.M., Resident #6 was observed in the main dining room. CNA #4 was observed to be feeding the resident. There was no weighted silverware at the table. CNA #4 was interviewed at that time. During the interview, CNA #4 indicated Resident #6 had difficulty feeding herself because her hands shook too much, she had trouble seeing, and she spilled her food. CNA #4 indicated she was not aware that Resident #6 was to use weighted eating utensils at meals. Certified Occupational Therapy Assistant [COTA] #6 was interviewed on 4/7/11 at 2:00 P.M. During the interview, COTA #6 indicated she had worked with Resident #6 in November 2010 and had recommended that the resident use weighted silverware at meals to assist her in maintain her independence in eating. The facility Dietary Manager was interviewed on 4/7/11 at 2:15 P.M. During the interview, he indicated he was not aware that Resident #6 had an order for weighted utensils at meals. He further indicated he would ensure that Resident #6 was provided with the weighted utensils and he would add instructions for weighted utensils on to Resident #6's meal tray card so that staff would know that the resident was to use weighted utensils. 2a. Review of the clinical record of Resident #3 on 4/4/11 at 10:45 a.m., indicated the following: diagnoses included, but were not limited to, chronic obstructive pulmonary disease, hypertension, anxiety, and depression. A physician's order for Resident #3, dated 3/30/11 and written by the Speech			

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	Language Pathologist #3, indicated to upgrade patient's diet from mechanical soft to regular food consistencies and continue with thin liquids. A current physician's order for Resident #3, for the month of April, 2011, indicated she was to receive a Mechanical Soft diet. A current meal tray card for Resident #3, provided by the Dietary Manager on 4/6/11 at 10:45 a.m., indicated she was to receive a Mechanical Soft Diet. Due to a potential problem with a gas leak in the kitchen on 4/4/11 10:00 A.M., the lunch menu was changed to cold food items on hand. The regular diet consisted of a cold meat sandwich, coleslaw, fruit cocktail, and a cookie. The mechanical soft diet consisted of a cold meat spread sandwich, coleslaw, fruit cocktail, and a cookie. During an observation of the lunch meal on 4/4/11 at 12:25 p.m., Resident #3 was observed to receive her lunch tray of mechanical soft foods in her room. The facility Cycle 1, 2010 Menu Calendar for Tuesday 4/5/11 lunch, provided by the Dietary Manager on 4/4/11 at 11:40 a.m., indicated the regular diet consisted of steak smothered with onion, au gratin potatoes, vegetable blend, a dinner roll			

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	with margarine and strawberry short cake (cantaloupe was substituted for the strawberry short cake). The mechanical soft diet consisted of chopped steak, au gratin potatoes, vegetable blend, a dinner roll with margarine and chopped cantaloupe. During an observation of the lunch meal on 4/5/11 at 12:05 p.m., Resident #3 was observed to receive her lunch tray of mechanical soft foods in her room. The facility Cycle 1, 2010 Menu Calendar for Tuesday 4/5/11 dinner, indicated the regular diet consisted of chicken quesadillas, salsa salad, Mexican rice, and pineapple slices with cherry. The mechanical soft diet consisted of mechanical soft chicken quesadillas diced tomatoes, Mexican rice, and applesauce. During an observation of the dinner meal on 4/5/11 at 6:00 p.m., Resident #3 was observed to receive her dinner tray of mechanical soft foods in her room. Speech Language Pathologist #2 was interviewed on 4/6/11 at 11:05 a.m. During the interview she indicated changes in diet consistencies were communicated from speech to dietary through a "Diet Order and Communication" form. She also indicated she had only been back in the facility as a therapist for 3 days.			

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	The Dietary Manager was interviewed on 4/6/11 at 2:34 p.m. During the interview he indicated a "Diet Order and Communication" form was initiated from a physician's order and the changes were then made to resident's meal tray card. He also indicated dietary had not received a "Diet Order and Communication" form concerning the upgrade in diet consistency from a Mechanical Soft diet to a Regular diet for Resident #3. The Director of Nursing was interviewed on 4/6/11 at 3:15 p.m. During the interview she indicated any order written by speech therapy was noted by nursing who then notified dietary of the change through a "Diet Order and Communication" form. A fax sent to the facility from Speech Language Pathologist #3, on 4/7/11 at 9:20 a.m., indicated she had screened Resident #3 on 3/30/11 to upgrade her from a mechanical soft diet to regular foods. The fax also indicated Resident #3 did not demonstrate any clinical signs or symptoms of aspiration with regular consistency foods. The fax further indicated Speech Language Pathologist #3 recommended Resident #3 be upgraded to regular foods and continue with thin liquids.			

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2b. A physician's order for Resident #3, dated 3/3/11, indicated to place TED hose on in AM and off in PM to bilateral feet and legs due to edema.

A current physician's order for Resident #3, dated for the month of April, 2011, indicated TED hose, on in morning and off at bedtime to bilateral feet and legs.

A Certified Nursing Assistant (CNA) assignment sheet, provided on 4/4/11 at 10:00 a.m. by the Director of Nursing, indicated TED hose for Resident #3.

During an observation on 4/5/11 at 11:00 a.m., Resident #3 was observed resting in bed in her room. She was not wearing TED hose.

During an observation on 4/5/11 at 2:10 p.m., Resident #3 was observed resting in bed in her room. She was not wearing TED hose. When queried about her TED hose, she whispered staff did not put them on her in the morning.

During an observation on 4/5/11 at 6:00 p.m., Resident #3 was observed resting in bed in her room. She was not wearing TED hose.

During an observation on 4/6/11 at 10:00

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	a.m., Resident #3 was observed resting in bed in her room. She was not wearing TED hose. 3. Review of the clinical record of Resident #29 indicated the following: diagnoses included, but were not limited to, hypertension and peripheral edema. A physician's order for Resident #29, dated 3/2011, indicated TED hose, put on in the morning and remove in the evening. A facility care plan for Resident #29, with a date of 6/21/09, indicated the problem of resident at risk for fluid imbalance related to diuretic therapy. Interventions to the problem included, but were not limited to, TED hose as ordered. A CNA assignment sheet, provided on 4/4/11 at 10:00 a.m. by the Director of Nursing, indicated TED hose on in AM and off in PM for Resident #29. During an observation on 4/6/11 at 10:00 a.m., Resident #29 was observed sitting in her easy chair in her room. She was not wearing TED hose. During an observation on 4/6/11 at 3:30 p.m., Resident #29 was observed sitting in her easy chair in her room. She was not wearing TED hose.			

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	CNA #1 was interviewed on 4/6/11 at 2:25 p.m. During the interview she indicated the CNA assignment sheet described the care each resident required. A current facility policy "Following MD Orders", dated 12/18/10, indicated "...It is the policy of Wesley Healthcare that all physician orders are to be followed...." 3.1-35(g)(2)			

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F0285 SS=D	A facility must coordinate assessments with the pre-admission screening and resident review program under Medicaid in part 483, subpart C to the maximum extent practicable to avoid duplicative testing and effort. A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental illness as defined in paragraph (m)(2)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission; (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for mental retardation. (ii) Mental retardation, as defined in paragraph (m)(2)(ii) of this section, unless the State mental retardation or developmental disability authority has determined prior to admission-- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for mental retardation. For purposes of this section: (i) An individual is considered to have "mental illness" if the individual has a serious mental illness defined at §483.102(b)(1). (ii) An individual is considered to be "mentally retarded" if the individual is mentally retarded as defined in §483.102(b)(3) or is a			

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	person with a related condition as described in 42 CFR 1009. Based on record review and interview, the facility failed to ensure Interdisciplinary Diagnostic and Evaluation Center (IDEC) reports for 2 of 3 residents with developmental disability was available in the clinical record (Resident #5 & 22). Due to lack of assessments, coordination between the IDEC and the facility was not conducted to develop care plans for the resident. The facility further failed to obtain mental health history and treatment for 1 of 4 residents with a psychiatric diagnosis in a sample of 13 residents (Resident #5). Findings include: 1a. Resident #5's record was reviewed on 4/5/11 at 5:00 p.m. The record indicated Resident #5's diagnoses included, but were not limited to, developmental disorder and schizophrenia. No IDEC report was noted in the clinical record. 1b. Resident #5's record was reviewed on 4/5/11 at 5:00 p.m. The record indicated Resident #5's diagnoses included, but were not limited to, developmental disorder and schizophrenia. The clinical record for Resident #5	F0285	1. SSD to initiate call to Bureau Of Developmental Disibilities for all residents with Level 2 dx to complete IDEC reports as necessary upon admission. This will be continuous, log will stop at 6 months.2. Residents that were noted to not have this completed at the time of survey-this has been completed. 3. QA to follow x 6 months4. SSD to log all admits that were referred to the Bureau of Developmental Disibilities x 6 months	04/25/2011

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	indicated she was admitted to the facility on 12/31/10 with a major mental health diagnosis of schizophrenia and did not include her past mental health history, treatment and behaviors in the last two years prior to admission. 2. Resident #22's record was reviewed on 4/5/11 at 11:30 a.m. The record indicated Resident #22's diagnoses included, but were not limited to, mild mental retardation and Prader-Willi syndrome. No IDEC report was noted in the clinical record. On 4/6/11 at 2:18 p.m. the Social Services Director was interviewed regarding the IDEC reports. She stated she was unsure what I was asking for. Indicated she would have to get back to me. On 4/6/11 at 2:54 p.m., the Social Services Director indicated that the facility where the two residents came from did not report to the Bureau of Developmental Disabilities that the residents had been moved and that she thought they were the ones responsible for notifying the office. She further indicated the reports were just faxed to her. 3.1-29(a)			

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	3.1-29(b)			
F0323 SS=E	The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview and record review, the facility failed to ensure chemicals and medications were kept secure in 2 of 3 treatment carts on two of three halls, East and West halls, potentially affecting 12 residents residing on the East Hall and 10 residents residing on West hall. Findings include: Census documented by room was provided by the Executive Director 4/5/11 at 8:30 a.m. and indicated 20 residents resided on the East hall and 12 residents resided on the West hall. A list of interviewable residents provided by the Social Services Director at 12 p.m. indicated 12 residents on East hall were confused and independently ambulatory or wheelchair capable and 10 residents on West hall were confused and independently ambulatory or wheelchair capable.	F0323	1. In-service completed as per attached on 4/18/112. DON or designee to monitor that carts are locked via direct observation 1x per week x 2 months, 2x per month x 2 months, 1x per month x 2 months. Documentation per attached log.3. QA to follow x 6 months.	04/25/2011

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	On 4/4/11 at 3:25 p.m. the West hall treatment cart was observed unlocked with contents accessible to persons in the hall. There were no residents observed in the hall at that time. The treatment cart contained silver sulfadiazine and bleach wipes. LPN # 7 was noted to walk down the hall from the nurse's station where she had been charting and secured the cart. On 4/5/11 between 5:15 p.m. and 6 p.m. the treatment cart on the East hall was observed unlocked with contents accessible to persons in the hall. There were 5 unidentified residents walking or independently propelling through the hallway. The treatment cart contained silver sulfadiazine, gentamycin/dakins solution, and iodoform gel. The manufacturer's warnings for silver sulfadiazine provided by the Executive Director on 4/7/11 at 8:30 a.m. indicated the medication was to be used for infections, but did not include warnings. The 2010 Nursing Spectrum Drug Handbook included precautions for use included eye irritation and may be			

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	harmful or fatal if swallowed. The manufacturer's warnings for gentamycin/dakins solution provided by the Executive Director on 4/7/11 at 8:30 a.m. included to avoid getting the medication in the eyes, nose or mouth, and to prevent getting the solution on healthy skin. The manufacturer's warnings for iodoform provided by the Executive Director on 4/7/11 at 8:30 a.m. included the formula for making iodoform gel with water, alcohol, sodium carbonate, and potassium iodide, but did not include warnings. In an interview 4/6/2011 at 8:55 a.m., the Executive Director indicated the treatment carts should remain secure. A current policy titled med/treatment carts dated 12/15/2010 indicated treatment carts were to be kept secure if they were not in visual sight of the nurse. 3.1-45(a)(1)			

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F0386 SS=A	The physician must review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; write, sign, and date progress notes at each visit; and sign and date all orders with the exception of influenza and pneumococcal polysaccharide vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications. Based on record review and interview, the facility failed to ensure all physician orders were dated for 2 of 13 residents reviewed with physicians orders in a sample of 13. (Residents' #1 and #5) Findings include: 1. Resident #1's record was reviewed on 4/4/11 at 11:25 a.m. The record indicated Resident #1's diagnoses included, but were not limited to, encephalopathy, ventilator dependant, vegetative state. The following signed physicians orders were undated as to when they were signed: - Telephone order for chest x-ray dated 3/20/11 - Pharmacy recommendation orders, printed 2/11/11 - Pharmacy recommendation orders, printed 1/17/11 - Pharmacy recommendation orders, printed 10/19/10	F0386	1. Medical Records clerk in-serviced on ensuring that the date is present on the telephone physician orders prior to filing them.Medical records clerk is the only person that files telephone orders in the charts and she/he will audit monthly while thinning charts for orders that do not have dates on them2. All charts audited by Medical records to ensure that all telephone orders are dated that are in current charts3. QA to follow x 6 months	04/25/2011

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	2. Resident #5's record was reviewed on 4/5/11 at 5:00 p.m. The record indicated Resident #5's diagnoses included, but were not limited to, schizophrenia, congestive heart failure and seizures. The following physician signed physicians orders were undated as to when they were signed: - Pharmacy recommendation orders, printed 2/11/11 - Telephone orders dated 2/15/11 and 2/16/11 3.1-22(c)(3)			

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	155666	A. BUILDING 00 B. WING	04/08/2011

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F0441 SS=D	The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.			
	Based on observation, interview and record review, the facility failed to ensure adequate handwashing during tracheotomy care for 2 of 4 residents observed receiving tracheotomy care in a	F0441	1. In-service completed as per attached on 4/18/112. Policy and procedure written specifically for trach care. We have contracted an RT to come in and work individually with each RT on how	04/25/2011

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	sample of 13 (Resident #D and Resident #E). Findings include: 1. Resident #E's record was reviewed on 4/5/2011 at 2:25 p.m. Resident #E's diagnoses included but were not limited to spinal cord infarction (death if part of the spinal cord), kidney failure, and anemia. During an observation on 4/6/11 at 11 a.m. Respiratory Therapist #8 washed his hands, gloved, then opened the trach care kit. Respiratory Therapist #8 then opened the saline, poured it into the sterile basin, opened the package for the new inner canula, loosened the ties, disconnected the ventilator circuit with both hands, and removed the old inner canula with his left hand, placed the new inner canula with his left hand, inspected the tracheotomy area, removed the old drain sponge, cleaned the stoma, opened the new drain sponge, placed the new drain sponge, then replaced the trach ties. Respiratory Therapist #8 did not wash his hands or change gloves during the procedure. A sputum culture obtained 1/28/2011 indicated Resident #E had an organism Serratia Marcescens isolated in his sputum.		to correctly do trach care per our policy. This is in addition to the above mentioned inservice.3. NN to be reviewed for accurate documentation on all residents on antibiotic therapy 1x per week x 2 months, 2x per month x 2 months, 1x per month x 2 months. Documentation per attached log.4. Policy written on how to handle clean linens and how to handle dirty linens.5. Policy written on how to care for a patient on isolation.6. Policy written on how to handle tube feed tubing when it is not attached to the resident7. DON or designee to monitor nurses for handeling of medications 1x per week x 2 months, 2x per week x 2 months, 1x per week x 2 months.8. DON or designee to monitor per direct observation for infection control violations 1x per week x 2 months, 2 x per month x 2 months, 1x per month x 2 months9. QA to follow x 6 months	

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	On 2/18/2011, a physician's order was received for Tobrex (an antibiotic) eye drops to be given for 7 days in each eye four times per day. A nurse's note dated 2/18/11 indicated Resident #E had eye redness in both eyes. On 3/7/11, a physician's order was received for Tobrex (an antibiotic) eye drops to be given in both eyes four times per day for 5 days to treat redness and itching eyes. This order was given 10 days after the 2/18 Tobrex order had been completed. Five days after the Tobrex is completed, on 3/17/2011, another order is obtained for Tobramycin eye drops to be given in both eyes four times per day for 5 days. There was no indication in the orders or nurse's notes why the medication had been ordered. One day after the last antibiotic was completed, on 3/23/2011 at 3 p.m., the nurse's notes indicate an order was received to culture eye drainage. There is no description of the type, color or amount of the eye drainage. On 3/23/2011, a physician's order was received to culture eye drainage and to start Ciloxin (an antibiotic) eye drops to			

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	both eyes four times per day for seven days. The culture results for the eye drainage obtained on 3/23/2011 indicated the organism responsible for the eye drainage was Serratia Marcescens, the same organism found in Resident #E's sputum. On 4/5/2011, the antibiotic was changed to an antibiotic the organism was sensitive to. In an interview the Director of Nursing on 4/5/2011 at 2:00 p.m. indicated the respiratory Therapist should have changed gloves and washed his hands between clean and dirty. 2. Resident #D's record was reviewed on 4/4/2011 at 11:30 a.m. Resident #D's diagnoses included but were not limited to Guillian-Barre" syndrome (progressive paralysis from feet to head), respiratory failure, and chronic pain. During an observation on 4/6/11 at 11 a.m. Respiratory Therapist #8 washed his hands, gloved, suctioned Resident #D with a closed system, opened trach care kit, put on a sterile glove over the contaminated glove on his right hand, loosened the trach ties with his left hand, reached over the gerichair and placed the			

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	trash can on the gerichair, with his right hand, opened the saline and poured it into the sterile basin, donned the sterile glove on his left hand, removed the soiled drain sponge with his right hand, washed around the trach site with his right hand, picked up the circuit with his left hand, placed the clean drain sponge with both hands, took the inner canula out with his left hand and placed the new inner canula in with his right. Respiratory Therapist #8 the reattached the trach ties, ungloved, placed the trash can back on the floor and washed his hands. A chest x-ray obtained 3/5/2011 indicated a left lower lobe infiltrate improved over 1/11/2011 finding. Resident #D was currently on Fortaz (an antibiotic) intravenously every 8 hours. This medication was initiated on 3/3/2011 at [name of hospital documented] Hospital. In an interview on 4/7/2011 at 11:58 a.m. Respiratory Therapist #11 indicated handwashing between dirty and clean was what we "the surveyors" wanted to see, but not necessarily the procedure in the hospitals. A procedure provided 4/7/2011 at 8:30 a.m. by the Director of Nursing for			

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	tracheostomy care did not indicate how the tracheotomy care was to be completed. 3. On 4/4/11 at 10:15 a.m., the following was observed: - CNA #12 observed carrying a clean incontinence brief and entering isolation room #302 and obtaining a box of gloves from the resident's bathroom before leaving the room. - CNA #12 then carried the brief and box of gloves with her into room #303 to answer a call light. After standing in the doorway to see what the resident wanted. - Next CNA #12 then entered room #301 to provide care and change the bedding. - CNA # 12 opened the door carrying soiled linen without wearing gloves and placed them in the linen barrel. She then went back into the room with the door open and rearranged items on the overbed table, exited the room and retrieved clean linen from the hall linen closet. She put the linen under her arm, closed the door then placed the linen up against her chest before carrying the linen into room #306 before closing the door. No handwashing was observed either with soap and water or hand sanitizer. 4. On 4/4/11 at 11:17 a.m., a tube feeding pump was observed in room #201. The pump was turned off with a bottle of tube			

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	feeding hanging from the pole. The end of the tubing, which gets connected to the resident's tubing coming from their abdomen, was unprotected with no end cap. It was placed directly into the back of the feeding pump which had dried tube feeding solution around the area. 5. On 4/4/11 at 12:15 p.m., a tube feeding pump was observed in room #308. The pump was turned off with a bottle of tube feeding hanging from the pole. The end of the tubing, which gets connected to the resident's tubing coming from their abdomen, was unprotected with no end cap. It was placed directly into the back of the feeding pump which had dried tube feeding solution around the area. 6. During a random observation on 4/5/11 at 5:09 p.m., RN #14 was observed punching two medication tablets directly into the palm of her hand before placing them into a medication cup. The nurse then crushed up the medication and went into room #306 where the resident received all of her medications crushed and administered thru a feeding tube into her stomach. 7. Upon entering Resident #5's room on 4/5/11 at 6:20 p.m., there was a strong			

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	odor of feces and two unidentified CAN's were providing care behind the curtain. On the floor was a large pile of soiled bedding and towels. This Federal tag relates to complaint number IN00088668. 3.1-18(k)			
F0513 SS=D	The facility must file in the resident's clinical record signed and dated reports of x-ray and other diagnostic services. Based on record review and interview, the facility failed to ensure x-ray results were available in the clinical record for 1 of 13 residents reviewed for x-rays in a sample of 13. (Resident #1) Findings include: Resident #1's record was reviewed on 4/4/11 at 11:25 a.m. The record indicated Resident #1's diagnoses included, but were not limited to, anoxia of the brain and respiratory failure (ventilator dependent). A telephone order, dated 3/20/11, indicated an order for a chest x-ray due to increased yellow secretions. During record review, no x-ray results were	F0513	1. In-service completed with all staff as per attached on 4/18/112. Current month labs in TAR audited to ensure that all were present in chart. 3. DON or designee to audit labs monthy x 6 months to ensure that all labs for previous month are present in the chart. This will begin May with April labs.This will include all diagnostic reports that we receive orders for. 4. QA to follow x 6 months	04/25/2011

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	located in the chart. During an interview on 4/5/11 at 9:30 a.m., the Director of Nursing (DON) indicated staff were slow at getting results on the chart and that the results are usually kept on a clipboard and then later filed. During an interview on 4/6/11 at 3:15 p.m., LPN #13 indicated the results of x-rays and labs come into the nurse's fax machine. At that point, the results are faxed to the physician and a copy is placed in the resident's chart. 3.1-49(j)(4)			
F0514 SS=D	The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. Based on record review and interview, the facility failed to ensure the administration of nexium was documented for 1 of 13	F0514	1. In-Service completed for all staff as per attached on 4/18/112. DON or designee to audit holes in the MAR 1x per week x 2 months,	04/25/2011

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	residents reviewed with medications (Resident #1). The facility further failed to ensure an accurate intake and output documentation for 1 of 6 residents reviewed on feedings tubes (Resident #1) and failed to ensure a copy of the resident advance directives were available for 1 of 13 residents reviewed for advance directives in a sample of 13 (Resident #1). Findings include: 1a. Resident #1's record was reviewed on 4/4/11 at 11:25 a.m. The record indicated Resident #1's diagnoses included, but were not limited to, respiratory failure, high blood pressure and GERD (gastroesophageal reflux disorder). The April 2011 routine medications sheets indicated an order for Nexium to be given daily at 8:00 a.m. The medication sheet was not marked for April 1, 2, 3, 4 as being administered. 1b. Resident #1's record was reviewed on 4/4/11 at 11:25 a.m. The record indicated Resident #1's diagnoses included, but were not limited to, respiratory failure, high blood pressure and GERD (gastroesophageal reflux disorder). The April 2011 routine medications sheet indicated Resident #1 had an order for		2x per month x 2 months, 1x per month x 2 months. Documentation per attached log.3. DON or designee to audit I&O's for completeness and accuracy 1x per week x 2 months, 2x per month x 2 months, 1x per month x 2 months. 4. Intake and Output policy updated to include that nurses are to zero out the pumps at the beginning of their shift to ensure accurate documentation of Intakes.5. SSD to ask for Advance Directives at admission and place in the chart. 6. SSD to audit all current charts for Advance Directives of patients who have them and ensure that they are in the chart7. QA to follow x 6 months8. SSD to audit charts monthly for advance directives in those who have them x 6 months	

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	tube feeding to run 21 hours a day at 60/cc hr (1260 cc/day) starting 9/30/10 to present. The January 2011 "Intake and Output Record" indicated Resident #1 received the following amounts (cc) of tube feeding in a 24 hour period of time: Of the 31 days in January, 25 of 62 shifts were blank with no documented shift intake/output or no documented shift/day totals. Of the 31 days of January, 30 of 62 shifts were documented with a total greater than the amount of tube feeding prescribed. On 4/5/11 at 4:15 p.m., the Director of Nursing (DON) indicated the I&O for Resident #1 was incorrect. When asked whether the totals received were taken from the feeding pump or whether staff were just putting down the totals of what was ordered, the DON indicated each nurse has their own procedure for whether they clear the pump or just write down the total ordered. The current policy "Enteral Feedings," dated 10/5/09, was provided by the DON on 4/5/11 at 5:50 p.m. The policy indicated "...Enteral feedings will be provided as per the physician's			

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	orders...intake to be measured on all enteral feeding patients...." 1c. Resident #1's record was reviewed on 4/4/11 at 11:25 a.m. The record indicated Resident #1's diagnoses included, but were not limited to, respiratory failure (ventilator dependant), encephalopathy and persistent vegetative state. No advance directives were located in the clinical record during review. The clinical record for Resident #1 listed an admission date of 8/13/10 and listed her as being a full code. The undated "Social Service Assessment," indicated Resident #1 had advance directives, which included a durable power of attorney and a health care representative. At 4:08 p.m., the Social Services Director provided a copy of the advance directives for Resident #1's and indicated it had gotten placed in the office financial's folder instead of the resident's chart. The current policy for "Advanced Directive Policy and Procedure" dated 3/1/10, indicated the following: "...the admission person is to obtain a copy of the Advanced Directive upon admission or request a copy of Advanced Directive. If the Advanced Directive is given at time			

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	of admission a copy is to be made and put under the Advance Directive tab in the resident's chart. Once a copy is requested, and one week goes by and no Advanced directive is received by the facility a letter is sent by social Services requesting it for the second time, and after a third letter is sent to family requesting information within 7 days then we cannot honor the Advance Directive...." 3.1-50(a)(1) 3.1-50(a)(2) 3.1-50(a)(3) 3.1-50(f)(2) 3.1-50(f)(4)			